

CERTIFICATE OF DEATH

Reg. Dist. No.

13149

13162

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SHOWELL				c. LENGTH OF STAY IN 1b 15 YRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GLADYS ALIDA BISHOP				4. DATE OF DEATH NOV 26 1959			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 2, 1904	
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours		11. IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME			
11. BIRTHPLACE (State or foreign country) NEW YORK CITY N.Y.				12. CITIZEN OF WHAT COUNTRY? U. S.A.			
13. FATHER'S NAME WILLIAM YONGE				14. MOTHER'S MAIDEN NAME ANNA DUFF			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NO			
17. INFORMANT MR. CHARLES BISHOP SHOWELL MD				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of ovary DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Cardiac failure				INTERVAL BETWEEN ONSET AND DEATH 1 year 3 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 1950 to November 1959 , that I last saw the deceased alive on November 26, 1959 , and that death occurred at W.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert A. Grubb MD				ADDRESS (Street, city or town, state) Bethesda, Md.			
PHYSICIAN'S NAME (Type) ROBERT A. GRUBB				DATE SIGNED 11/27/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/29/59		22c. NAME OF CEMETERY OR CREMATORY ODD FELLOWS		22d. LOCATION (City, town, or county) (State) BISHOPVILLE MD	
23. FUNERAL DIRECTOR'S SIGNATURE Anne H. Burbage Berlin md				24a. REC'D BY REGISTRAR DEC 1 '59			
				24b. REGISTRAR'S SIGNATURE Charles S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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13163

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Bishop</u> Last <u>Bishop</u>		4. DATE OF DEATH Month <u>7/01</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10-1890</u>
9. AGE (In years last birthday) <u>79</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>11</u> Days <u>23</u> Hours <u>00</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lincoln Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Bishop</u>		14. MOTHER'S MAIDEN NAME <u>Embrow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. ADDRESS <u>McClonzo Bishop, Snow Hill, md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> 443X DUE TO <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>UNKNOWN</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPOTHTIC PNEUMONITIS</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>11/17/59</u> , 19 <u>59</u> , to <u>11/23/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/22/59</u> , 19 <u>59</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Robert C. LaMar</u>		DATE SIGNED <u>11-24-59</u>	
PHYSICIAN'S NAME (Type) <u>Robert C. LaMar, M.D.</u>		ADDRESS (Street, city or town, state) <u>104 Bay Street, Snow Hill, Md., 11-24-59</u>	
22a. JOURNAL, CREMATION, REMOVAL (Specify) <u>Funeral</u>		22b. DATE THEREOF <u>Nov 25/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Good Spring</u>		22d. LOCATION (City, town, or county) (State) <u>Shallotte, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton E. Linn</u>		24a. REC'D BY REGISTRAR <u>Nov 25 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13164

CERTIFICATE OF DEATH

13151

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN				c. LENGTH OF STAY IN 1b All his life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RAILROAD AVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Thomas First Hi Middle Briddell Last				4. DATE OF DEATH Month 11 Day 30 Year 1959			
5. SEX M		6. COLOR OR RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-8-1877	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSERY WORK		11. BIRTHPLACE (State or foreign country) MARYLAND	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSERY WORK		10b. KIND OF BUSINESS OR INDUSTRY Planting		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISAAC BRIDDILL				14. MOTHER'S MAIDEN NAME ELLEN PARSONS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 218-20-5276			
17. INFORMANT MR. Wm. Briddell, Flower St, Berlin, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Some years				INTERVAL BETWEEN ONSET AND DEATH 15 minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 12-8 , 19 53 to 10-20 , 19 59 , that I last saw the deceased alive on 11-20 , 19 59 , and that death occurred at 6:55 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ivory U. Sully, Jr. M.D.				ADDRESS (Street, city or town, state) Berlin, Md.			
PHYSICIAN'S NAME (Type) Ivory U. Sully, Jr. M.D.				DATE SIGNED 11-22-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-23-59		22c. NAME OF CEMETERY OR CREMATORY EVERGREEN CEM.		22d. LOCATION (City, town, or county) (State) BERLIN, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Jolley, Salisbury, Md.				24a. REC'D BY REGISTRAR NOV 25 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

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CERTIFICATE OF DEATH

AND STATE DEPARTMENT OF HEALTH - DIVISION OF VITAL RECORDS

RECORDED
INDEXED

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13165

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DELLA M A E BRITTINGHAM</u>		4. DATE OF DEATH Month Day Year <u>NOV. 14 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 13 1883</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN NATHANIEL BRITTINGHAM</u>		14. MOTHER'S MAIDEN NAME <u>MARY LEWIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>MR. JOHN BRITTINGHAM</u> Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Haemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerosis</u> DUE TO (c) <u>Pulmonary Embolism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Nov 6</u> <u>8 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 6 -</u> , 1959, to <u>Nov 14 -</u> , 1959 that I last saw the deceased alive on <u>Nov 13 -</u> , 1959, and that death occurred at <u>3:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas. R. Law</u>		ADDRESS (Street, city or town, state) <u>Berlin Md</u> DATE SIGNED <u>Nov 14 - 59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/16/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>TIMMONS</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD RFD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Embury</u> ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR <u>NOV 18 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13166

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Worcester</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i>				c. LENGTH OF STAY IN 1b <i>1 yr</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Berlin Nursing Home</i>				e. STREET ADDRESS <i>Caroline St.</i>			
3. NAME OF DECEASED (Type or print) <i>FRANK</i> First <i>M.</i> Middle <i>COLLINS</i> Last				4. DATE OF DEATH <i>Nov</i> Month <i>5</i> Day <i>19 59</i> Year			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 5 1871</i> yrs.	
9. AGE (In years full birthday) <i>88</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Railroad</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William V. Collins</i>				14. MOTHER'S MAIDEN NAME <i>Jenny Hudson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO. <i>✓</i>		17. INFORMANT <i>Home Records</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442x Acute attack Myocarditis</i> DUE TO (b) <i>Chr. Nephritis & Myocarditis</i> DUE TO (c) <i>Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <i>3 AMO</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug</i> 1959, to <i>Nov 5</i> 1959, that I last saw the deceased alive on <i>Nov 4</i> 1959, and that death occurred at <i>6:30 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Chas R. Law</i>				ADDRESS (Street, city or town, state) <i>Berlin Md</i> DATE SIGNED <i>Nov 5 59</i>			
PHYSICIAN'S NAME (Type) <i>✓</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/7/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Parrons</i>		22d. LOCATION (City, town, or county) (State) <i>Sakshung, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edwin Whaley Selwyn, Jr.</i> ADDRESS				24a. REC'D BY REGISTRAR <i>NOV 9 1959</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kenna</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Reg. Dist. No.

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b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CARRIE PURNELL HANLEY		4. DATE OF DEATH Month Day Year Nov. 12 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 28, 1880
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) BERLIN MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM PURNELL		14. MOTHER'S MAIDEN NAME ELLEN LEONARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. 216-09-2813	
17. INFORMANT Mr RINALDO HANLEY		Address BERLIN MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO (b) Epithelioid CARCINOMA of FACE DUE TO (c) Epithelioid CARCINOMA of FACE Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH 2 yrs 5 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary atherosclerotic cardiovascular disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1956 to Nov 12 1959 , that I last saw the deceased alive on Nov 12 1959 , and that death occurred at 5:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. P. Thomas M.D.		ADDRESS (Street, city or town, state) Phila at North DATE SIGNED 11/14/59	
PHYSICIAN'S NAME (Type) N. R. THOMAS M.D.		OCCUPANCY, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/15/59	22c. NAME OF CEMETERY OR CREMATORY BUCKINGHAM	22d. LOCATION (City, town, or county) (State) BERLIN MD
23. FUNERAL DIRECTOR'S SIGNATURE Anna R Burbage ADDRESS Berlin Md		24a. REC'D BY REGISTRAR DATE NOV 16 '59	24b. REGISTRAR'S SIGNATURE C. R. S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

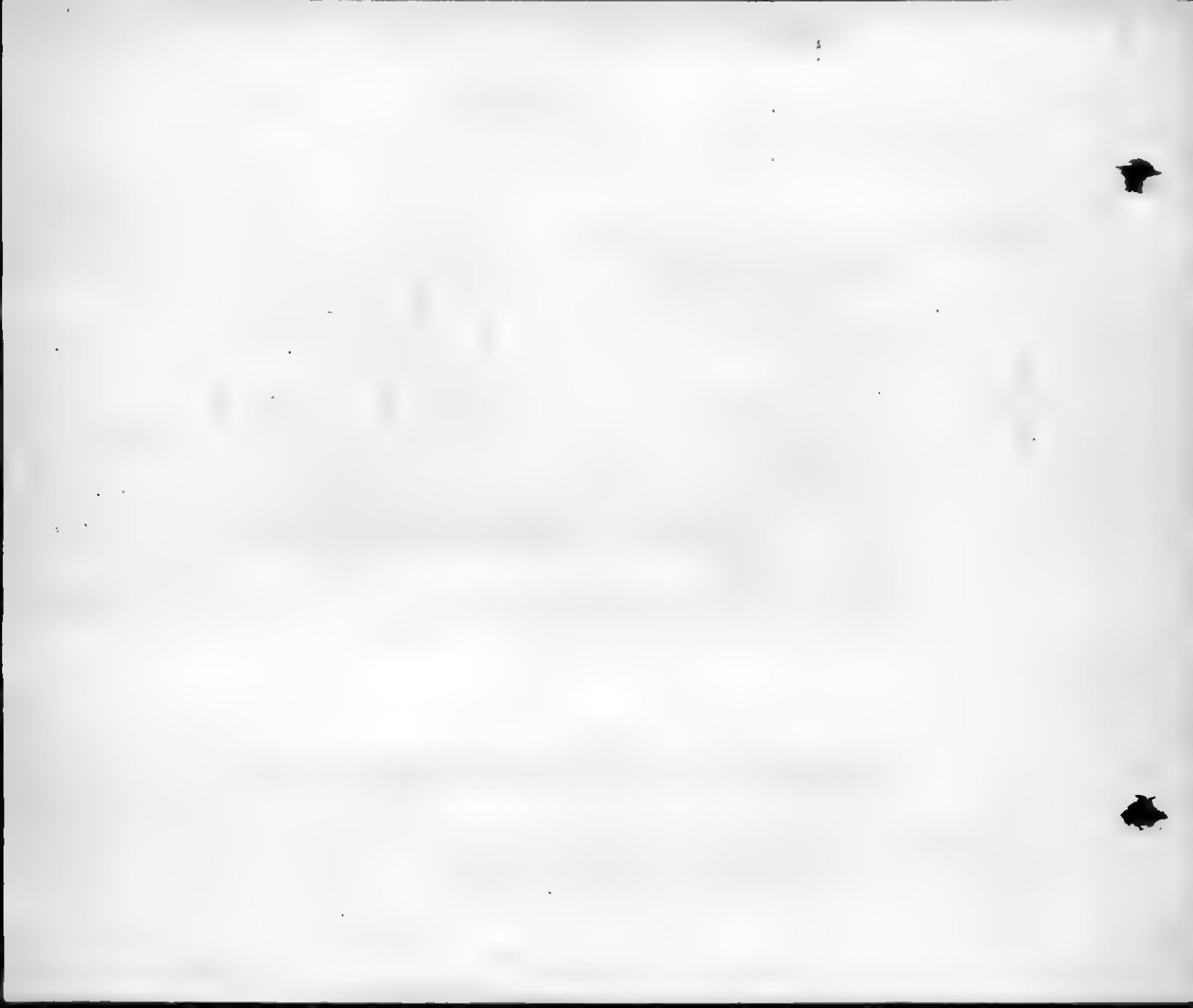
VS A15 (4)
TSM 9/58



13168 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 8k9 File 0253 12-11-59 et
CERTIFICATE OF DEATH

Reg. Dist. No. 13155

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>33A-11N ST. MARTINS</u> 77JL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BERLIN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOUIS CALVIN HUDSON</u>		4. DATE OF DEATH Month Day Year <u>Nov. 29 1959</u>	
5. SEX <u>M?</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1883 AUG. 2, 1882</u> 77JL
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HILARY HUDSON</u>		14. MOTHER'S MAIDEN NAME <u>CAROLYN BAKER.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Mrs L CALVIN HUDSON</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>acute arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>4-5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, Senile Degenerations</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1956</u> to <u>July 1959</u> , that I last saw the deceased alive on <u>Nov. 29 1959</u> , and that death occurred at <u>2:30 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Grubb, M.D.</u>		ADDRESS (Street, city or town, state) <u>BERLIN, MD</u> DATE SIGNED <u>12/1/59</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT A. GRUBB, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/1/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u> ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR <u>DEC 4 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13169 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13156

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) US 113 NR. SNOW HILL MD 1 YR.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) POCOMOKE CITY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS 719-A - SIXTH ST	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle JONES Last JONES		4. DATE OF DEATH Month NOV. Day 25 Year 1959	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 23, 1936
9. AGE (In years last birthday) 22 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY POULTRY PLANT	
11. BIRTHPLACE (State or foreign country) SAMPSON, ALABAMA		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME RUBEN JONES		14. MOTHER'S MAIDEN NAME DELLA ANDERSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 44341823	
17. INFORMANT ESSIE WILLIAMS		Address POCOMOKE CITY	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL CONCUSSION + HEMORRHAGE 819X DUE TO HEAD INJURY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HEAD INJURY DUE TO (c) HEAD INJURY			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HEAD INJURY			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) AUTO COLLISION E SERVICE POLE + BODY THROWN FROM CAR	
20c. TIME OF INJURY Month NOV Day 25 Year 1959 Hour 10 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) US 113 - 4 MI. S. OF SNOW HILL		20f. (City or town) (County) (State) WORCESTER MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert C. Lamar		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert C. Lamar, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-6-59	
22c. NAME OF CEMETERY OR CREMATORY Sampson Cem.		22d. LOCATION (City, town, or county) (State) Sampson Alb	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar W. Watson - New Church, Md.		24a. REC'D BY REGISTRAR DEC 2 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G253 12-11-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

13170

13157

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SNOW HILL				c. LENGTH OF STAY IN 1b 16 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home				ii. STREET ADDRESS 1P		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWIN DERRICKSON LYNCH				4. DATE OF DEATH Nov. 29 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 5, 1888		9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHERIFF		10b. KIND OF BUSINESS OR INDUSTRY COUNTY		11. BIRTHPLACE (State or foreign country) BERLIN MD		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME LEVIN D. LYNCH				14. MOTHER'S MAIDEN NAME SARAH ANN COFFIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-34-8808		INFORMANT Mrs. E. D. LYNCH		Address SNOW HILL, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Myocarditis DUE TO diabetes mellitus (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 day 2 yr 2 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957 , 19. to Nov 29 , 1959, that I last saw the deceased alive on Nov 28 , 1959, and that death occurred at 12:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul Cohen				ADDRESS (Street, city or town, state) SNOW HILL MD		DATE SIGNED 11-30-59	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/2/59		22c. NAME OF CEMETERY OR CREMATORY EVERGREEN		22d. LOCATION (City, town, or county) (State) BERLIN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage				ADDRESS Berlin Md		24a. REC'D BY REGISTRAR DEC 3 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

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